

Town of Manchester, Connecticut

BENEFIT	High Deductible Health Plan/ Health Savings Account		BENEFIT	High Deductible Health Plan/ Health Savings Account
Costshares	Health Savings Account		Inpatient Hospital	Health Savings Account
	Deductible - \$2,000/\$4,000		General/Medical/Surgical/ Maternity (Semi-private)	Covered 100% after plan deductible met
	Coinsurance - 100% after plan deductible met for in network services			
	\$4,000/\$8,000 out of pocket maximum		Ancillary Services	Covered 100% after plan deductible met
	Coinsurance - 80% after plan deductible met for out of network services		Medication, Supplies	
	Employer Contribution		Psychiatric	Covered 100% after plan deductible met Unlimited days
	\$1,000 single coverage			
	\$2,000 double or family coverage		Substance Abuse/Detox	Covered 100% after plan deductible met Unlimited days
	Lifetime Maximum In-Network - Unlimited		Skilled Nursing/Rehabilitation Facility	Covered 100% after plan deductible met Covered up to 180 days per calendar year
	Lifetime Maximum Out-Of-Network - Unlimited			
Preventive Care			Hospice	Covered 100% after plan deductible met
Pediatric	Covered			
			Outpatient Hospital	
Adult	Covered		Outpatient Surgery	Covered 100% after plan deductible met
			Facility Charges	(Prior Authorization Required)
Hearing	Covered		Diagnostic Lab & X-ray	Covered 100% after plan deductible met
	Screening part of physical exam			
Gynecological	Covered		Pre-Admission Testing	Covered 100% after plan deductible met
Medical Services			Other Services	
Medical Office Visit	Covered 100% after plan deductible met		Durable Medical Equipment	Covered 100% after plan deductible met
Outpatient PT/OT/ST/Chiro.	Covered 100% after plan deductible met		Prosthetics	Covered 100% after plan deductible met
	60 Combined Days			
	per calendar year per member			
Allergy Services	Covered 100% after plan deductible met		Home Health Care	Covered 100% after plan deductible met Unlimited days
				(Prior Authorization Required)
			Vision	Covered 100% after plan deductible met Covered once every 24 months
Diagnostic Lab & X-ray	Covered 100% after plan deductible met			
Inpatient Medical Services	Covered 100% after plan deductible met		Prescriptions (Coverage through Cigna)	Covered 100% after plan deductible met
Surgery Fees	Covered 100% after plan deductible met		* All benefits listed are for In-Network. For Out-of-Network benefits, please refer to your Employee Benefit Summary.	
Office Surgery	Covered 100% after plan deductible met		** Plan is Non-Gatekeeper. No referrals are required. No primary care physician is required.	
Outpatient MH/SA	Covered 100% after plan deductible met		INFERTILITY: Coverage is subject to a \$5,000 lifetime maximum	
Emergency Care			ELIGIBILITY: Effective July 1, 2010 dependent children covered to age 26 for medical and prescription plans due to the passing of the Health Care Reform Act of March 30, 2010.	
Emergency Room	Covered 100% after plan deductible met			
Urgent Care	Covered 100% after plan deductible met			
Ambulance	Covered 100% after plan deductible met			